Center for Treatment and Study of Anxiety
University of Pennsylvania
215-746-3327

Thank you for your request for information regarding our intensive treatment program for obsessive-compulsive behavior (OCD).

Patients are initially evaluated to determine suitability for treatment based on: a) a primary diagnosis of obsessive-compulsive disorder and b) sufficient severity to warrant therapist-assisted treatment. Individuals with problems other than obsessive-compulsive disorder may be referred to our general clinic or elsewhere for appropriate treatment (e.g. individuals with "impulse-control" problems, such as gambling, overeating and alcoholism).

Patients with moderate to severe OCD may enter our intensive individual treatment program. Patients for whom an intensive treatment program is not practical or unnecessary may receive treatment tailored to their clinical needs (e.g., once or twice a week). Typically, the OCD treatment program includes seventeen 90-minute sessions. If deemed necessary, two additional home visits are conducted. Also, if progress is made during the seventeen sessions but the patients still have significant residual OCD symptoms, additional sessions may be recommended. The focus of the first sessions is on gathering information, monitoring the symptoms and creating a treatment plan. The focus of the remainder of the sessions is on exposure and ritual prevention, on relapse prevention, and on future planning. The intensive program is designed for persons who come to Philadelphia from out of town, for persons with very severe OCD symptoms, or for people who have taken time off from work or school to focus on treatment.

Persons who live beyond daily commuting distance from our clinic (e.g., out-of-state) can stay at a nearby hotel at their own expense or at a hosting family at no cost (see below for information about Hosts for Hospitals). We recommend that a person coming for treatment be accompanied by a friend or a relative who can stay with them at least during the initial treatment period.

If deemed necessary and practical, the therapist may come to the patient's home for a couple of home visits to facilitate the transfer of gains made during treatment to the home environment . If treatment for other problems is indicated following completion of the treatment phase, patients will either be referred to an appropriate therapist in their home area or continue to receive treatment in our clinic on an 'as needed' basis.

Patients' progress is assessed at the beginning and end of treatment. Follow-up phone calls are scheduled for several weeks after the acute treatment phase, to help patients implement the treatment techniques and maintain their gains. If a recurrence of symptoms is noted at follow-up, further treatment may be recommended.

Effective January 1, 2011 the fee for intensive treatment is $9,000. This includes the initial evaluation and seventeen treatment sessions. If home visits are necessary, there will be an additional charge of $500 per visit + the therapist's expenses for the home visit (round trip transportation and overnight hotel accommodations). Additional treatment sessions beyond the seventeen sessions will cost $500 per session.

Depending upon the policy, medical insurance plans may reimburse patients for a percentage of the out-patient cost. We will do our best to assist with paperwork required for reimbursement. We do ask, however, that fees be paid directly to the clinic during the course of the treatment. For the fee schedule, please see page 3 of this packet.

For additional information about this program or for making an appointment for the initial evaluation, please contact the CTSA at (215) 746-3327.

Sincerely,

Edna B. Foa, Ph.D.
Professor of Clinical Psychology in Psychiatry
Director, Center for the Treatment and Study of Anxiety

Fee Schedule for OCD Intensive Treatment

Payment for the treatment is as follows:

$500 for the evaluation
$2,500 at the start of the first week
$2,500 at the start of the second week
$2,500 at the start of the third week
$1,000 at the end of the 17-session treatment program

If home visits are required, there will be an additional charge of $500 per visit. The therapist's expenses for the home visit are additional and borne by the patient. They include round trip transportation and overnight hotel accommodations, if needed.

Obsessive-Compulsive Disorder: Some Facts

Overview of OCD

It is estimated that approximately 2% of the population in the USA have obsessive-compulsive disorder (OCD). It has been observed in all age groups, from school-aged children to older adults. OCD typically begins in adolescence, but may start in early adulthood or childhood. The onset of OCD is typically gradual, but in some cases it may start suddenly. Symptoms fluctuate in severity from time to time, and this fluctuation may be related to the occurrence of stressful events. Because symptoms usually worsen with age, people may have difficulty remembering when OCD began, but can sometimes recall when they first noticed that the symptoms were disrupting their lives.

Your learning more about your OCD symptoms will help you get more improvement from this treatment. OCD is a set of habits that, as you may know, involves intrusive, unwanted, and upsetting thoughts, ideas, images, or impulses (**obsessions**). Along with these thoughts, you have unwanted feelings of extreme discomfort or anxiety and strong urges to do something to reduce the distress. Because of this, people get into the habit of using various special thoughts or actions to try to get rid of the anxiety (**compulsive rituals**). In addition, you may be aware of certain situations, places, or objects that trigger the distressing thoughts and urges to ritualize. You may find yourself avoiding these situations, places, and objects. These habits of thinking, feeling and acting are extremely unpleasant, wasteful, and difficult to get rid of on your own.

The causes of OCD

The reasons why some people develop obsessions and compulsions while others don't are unknown. Many researchers suggest that people with OCD have abnormal brain chemistry involving *serotonin*, a chemical that is important for brain functioning. Unusual serotonin chemistry has been observed in people with OCD and medications that relieve OCD symptoms also change serotonin levels. However, it is not known whether serotonin chemistry is truly a key factor in the development of OCD.

There is also evidence that OCD has a hereditary factor, and is more prevalent in some families than others. Most likely, there is a combination of factors (such as biological/genetic and environmental aspects) that contribute to the development of OCD.

Some experts have suggested that some specific “thinking mistakes” occur in OCD. Examples of such thinking mistakes are:

- Thinking about an action is the same as doing it, or wanting to do it
- People should control their thoughts
- If I don’t try to prevent harm, it’s the same as causing harm
- A person is responsible for harm, regardless of the circumstances

The two important associations in OCD

Two types of associations are a very important part of OCD, and understanding both of them will help with your therapy. First is the association between certain objects, thoughts, or situations and anxiety or discomfort. For example, touching a toilet flusher or thinking about accidentally harming someone produces distress. The second type of association is an association between carrying out rituals and decreasing the distress. In other words, after you perform your rituals you *temporarily* feel less anxious. Therefore, you continue to engage in this behavior frequently to achieve more relief. Therapy is designed to break both types of associations.

Unfortunately, doing rituals to reduce distress doesn’t work all that well. Your distress goes down for a short time and comes back again. Often, you find yourself doing more and more ritualizing to try to get rid of the anxiety. Even then, the rituals do not reduce the distress, and before long, you are putting so much time and energy into rituals that other areas of your life get seriously disrupted.

In order to treat OCD, the associations described above must be weakened or broken. Your therapy is designed to do this and your therapist knows exercises that will be helpful in achieving this goal. These exercises are called **exposure and ritual prevention** and you will learn more about them in the next section.

Understanding Cognitive-Behavior Therapy for OCD

Cognitive-behavior therapy is a type of treatment that helps individuals cope with and change problematic thoughts, behaviors, and emotions. The treatment you are beginning is a specialized type of cognitive-behavior therapy for obsessive-compulsive disorder (OCD) called *Exposure and Ritual Prevention (EX/RP)*. This treatment is designed to break two types of associations that occur in OCD. The first one is the association between sensations of distress and the objects, situations, or thoughts that produce this distress. The second association is between carrying out ritualistic behavior and decreasing the distress. In order to help break these associations, this treatment program includes three main components: *in vivo exposure, imaginal exposure,* and *ritual prevention*.

In Vivo Exposure: Exposures in "real-life" entail deliberately approaching a feared object or situation that evokes anxiety and distress (for example, coming in contact with contaminants) and staying in its presence for a period of time

Imaginal Exposure: Exposures in imagination entail visualizing oneself in the feared situations including the consequences of the feared situations (for example, visualizing driving on the road and hitting a pedestrian)

Ritual Prevention: Entails refraining from ritualistic behavior (for example, leaving the kitchen without checking the appliances, or touching dirty laundry without washing one's hands)

What is Exposure?

Exposure is a procedure in which you purposely confront objects or situations that you know produce distress and you stay in the presence of those objects or situations long enough for your anxiety to decrease by itself. ***In vivo exposure*** is a type of exposure that involves confronting feared objects and situations in real life. For example, a person who fears contamination by being in a public restroom would purposefully visit a public restroom and stay there for a long enough time to have their anxiety begin to decrease. As is often the case, you may believe that your discomfort will escalate or last forever unless you avoid such situations or escape from them when your anxiety or distress starts to rise. You may feel that you couldn't otherwise handle the situation. However, as you will find out, this is not necessarily true. At first, you can expect to feel anxiety or discomfort, since these are situations that are designed to activate your fears. However, after repeated exposure practice, such situations will no longer make you feel as uncomfortable as they once did. This process is called ***habituation***.

Many sufferers have expressed the following bewilderment: If habituation works, why hasn't my distress become less severe through the many encounters with situations that have provoked obsessions and anxiety in the past? The answer is that simply provoking an obsession is not enough. Exposure to the trigger of the obsessional distress must be done for a long enough time to allow the distress to diminish on its own, without removing oneself from the situation or without doing a ritual. In addition, like almost all learning of new skills, especially ones that have become habits, the exposure must be done repeatedly to have an optimal effect, thus helping to break the OCD.

Sometimes, it is impossible or impractical to actually confront your feared situation and its perceived consequences through in vivo exposure. For example, a person may fear that his house will burn down if he did not thoroughly check to ensure that the stove or an iron has been turned off. It would not be a good idea to suggest that the person burn his house down to allow him to confront that kind of fear. Instead, the person can confront the resulting harm by visualizing it in their imagination. In ***imaginal exposure***, you create in your mind a detailed and vivid sequence of images depicting the catastrophic disaster that you believe will occur if you do not avoid or ritualize. As in actual exposure, the obsessional distress gradually decreases during imaginal exposure.

Imaginal exposure is also helpful for individuals whose obsessions occur spontaneously and are not triggered by any identifiable situation. For example, a person might have a blasphemous thought at any time or place. This thought may cause them distress. In this case, there is no particular situation for the person to confront and the person can't practice remaining in the exposure situation for a prolonged period of time. With imaginal exposure, the blasphemy can be imagined repeatedly, without trying to eliminate it or neutralize it with a ritual.

Imaginal exposure may also be used to make subsequent in vivo exposure practices easier for you. If you are extremely distressed about the idea of confronting a situation or object that provokes your obsession, you may find it helpful to *imagine* confronting it first. The decrease in your distress during imaginal exposure will carry over to the actual exposure.

What is Ritual Prevention?

When people with OCD encounter their feared situations or have obsessional thoughts, they become anxious and feel compelled to perform ritualistic behaviors to reduce the distress. Exposure practices can cause this same distress and the same urge to ritualize. Therefore, in treatment, ***ritual prevention*** is practiced to break the habit of ritualizing. We know that rituals are difficult to stop because they bring relief from anxiety or discomfort. However, the performance of these rituals is currently greatly interfering with your ability to function in a variety of settings, and is one of the main reasons that you have sought treatment. Ritual prevention requires that you stop ritualizing, even though you are

still having urges to do so. Your therapist will teach you how to stop rituals and will introduce you to healthier ways of coping with and managing your discomfort.

Why should I do Exposure and Ritual Prevention?

Perhaps you are asking yourself, "Why should I suffer the distress of confronting feared situations on purpose without doing some rituals to get relief?" Remember that this treatment program is designed to weaken the two associations mentioned earlier. 1) The connection between distress and the objects, situations, or thoughts that trigger distress; and 2) The connection between ritualizing and relief from distress. As you know, after you carry out a ritual, you temporarily feel less distress. This temporary relief is what makes you continue to engage in the ritual, which in turn makes your OCD stronger. However, by not doing rituals, you help to weaken the connection between rituals and feeling better, ultimately weakening your OCD.

In addition to weakening connections, this treatment program is designed to help correct mistaken ideas that are common in OCD and cause considerable distress. ***The first mistaken belief commonly seen in people with OCD is that it is necessary to avoid or ritualize in order to prevent harm***. Most people can think of potential disasters that might happen to them or to others when they carry out necessary daily activities, such as driving a car. However, because they can think about the risk without disabling distress, they can see that the actual risk is relatively low and it should be ignored. Many people with OCD, however, become overwhelmed with distress (e.g., anxiety, guilt) when they think about certain potential disasters that might happen to them or to others. For example, individuals with OCD might become intensely anxious about the thought of their house catching fire, of being possessed by the devil, or by contracting a fatal disease. The intense anxiety prevents them from making rational and informed judgments about the relative risk of a situation and about what they can do to protect themselves or others. To be on the safe side, the person with OCD will opt to avoid or to ritualize in order to prevent even the most remote possibility of harm. Consequently, the individual does not have the opportunity to learn that the feared situation is actually relatively safe.

Exposure works against this type of mistaken idea. When you actually confront a feared situation repeatedly and don't ritualize, you realize that the predicted harm does not materialize. Thus, you recognize that the risk is remote and you learn to ignore it. For example, a woman who was afraid that her house would catch fire, refused to use her central heating even in cold weather. During therapy, she practiced turning on the heater and leaving it on while she was away from home. After a few hours, when the woman returned, the house was comfortably warm inside, but did not catch fire and she learned that her fear was unfounded.

The second mistaken belief commonly seen in people with OCD is that they must avoid the distressing situation or they will be distressed forever. This leads them to avoid many situations or to ritualize if they cannot avoid them. However, during

prolonged exposure, intense anxiety gradually decreases. If someone confronts a distressing situation for a prolonged period of time (such as 1-2 hours), the individual will experience a gradual decrease in distress until the distress is much lower. As the distress drops, it becomes easier to see whether or not a situation is actually dangerous. When a similar situation arises later, there will be far less distress than experienced previously.

A third mistaken belief commonly seen in people with OCD is that if they don't avoid or ritualize, the distress will get so bad that they will lose my mind. For example, a man was concerned that if things were not arranged in precisely the correct order, he would be so uncomfortable that he would not be able to stand it, he would lose his mind, and would be committed to a psychiatric hospital. During treatment, he purposely rearranged his office and bedroom and did not put things back in order even though he became distressed. Instead, his discomfort eventually decreased and he did not lose his mind. He learned that anxiety did not produce insanity.

A program that involves prolonged exposure is designed to help you, regardless of the content of your obsessions and the type of compulsions you perform. Thus, it can be applied effectively whether you are afraid of contracting a disease, causing accidents, discarding something important, saying inappropriate things, etc. As you will find out, when you first confront your feared situation, your distress will increase. However, as you remain in the situation, and do so repeatedly, the distress will diminish.

How involved do I need to be in Exposure and Ritual Prevention?

For in vivo and imaginal exposure to be helpful, you must become emotionally engaged during the exposure exercises. Specifically, the exposure situation must evoke the same kind of obsessional distress that you experience in your daily life when you encounter these situations. To promote emotional engagement, we will develop exposure exercises that are a good match to the real-life situations that provoke your obsessions and urges to ritualize. For example, if you are distressed by contamination related to cancer and you visit a hospital with no cancer ward, the exercise will not be helpful. This is because the situation does not match your fear so it will be hard for you to become emotionally involved.

During the exposure exercises that are a good match to your obsessions, you should pay attention to the distressing aspects of the exposure situation, rather than trying to ignore them or distract yourself. This is true for both imaginal and in vivo exposure. For example, in the previous example, if you pretend that a cancer ward is really a cardiac unit in order to reduce your distress, the exercise will be less effective. To make the exposure effective, you should think about the potential harm that concerns you. For example, if you are afraid of using public restrooms, a good exposure exercise will be to go to a public restroom. While there, you must think about what concerns you have about the restroom, such as how dirty it might be or what diseases you are afraid of contracting. Similarly,

during imaginal exposure, you should include anticipated disasters and focus on imagining them as vividly as you can.

How can I get the most benefit out of Exposure and Ritual Prevention?

When people hear about exposure treatment, they often do not understand how it works. You might think that if you just decide to do things that you avoid and give up doing rituals, you really wouldn't need treatment at all. Most people with OCD can temporarily stop their avoidance and rituals, but they find that very uncomfortable and they don't see why anyone would willingly want to go through it. Certainly you have had occasions when you accidentally or purposely confronted feared situations, but your OCD habits persisted. To increase the success of exposure and ritual prevention, one must do well-designed exercises, and do them correctly. In this treatment, exposure exercises will be designed specifically for your OCD symptoms and your therapist will coach you as you practice them.

What you get out of exposure and ritual prevention depends heavily on what you put into it. It also depends on you and your therapist collaboratively coming up with an exposure plan that fits your particular OCD habits. Sometimes exposure exercises may seem counterintuitive or even extreme, but it will be important for you to practice them anyway. A legitimate inquiry is often made by sufferers of OCD whether 'normal people' do those extreme things. The answer is that extreme measures are required for extreme disease conditions. So, for example, 'normal people' do not get radiation and/or chemotherapy unless they are fighting cancer. You are willingly participating in exposure and ritual prevention in order to best fight your OCD.

Hotel/Bed & Breakfast Listing

Listed below are a few names and addresses of hotels in the Philadelphia area that you may be interested in.

CLUB QUARTERS PHILADELPHIA	1628 Chestnut Street Philadelphia, PA 19103 (215) 282-5000
BED AND BREAKFAST	1804 Pine Street Philadelphia, Pa. (215) 735-1137
CROWNE PLAZA PHILADLPHIA	City Line Avenue and Presidential Boulevard Philadelphia, Pa. (215) 477-0200
KORMAN SUITES	One Buttonwood Square 2001 Hamilton Street Philadelphia, Pa. (215) 569-7000
MCINTOSH INN	King of Prussia Mall 260 N. Gulph Road King of Prussia, Pa. (610) 768-9500
PRESIDENTIAL APTS.	City Line Avenue and Presidential Boulevard Philadelphia, Pa. (215) 883-2000 (Ask for corporate rental rates)
INN AT PENN	3600 Sansom Street Philadelphia, Pa. 19104 (215) 222-0200 (Ask for patient package)
SHERATON UNIVERSITY CITY HOTEL	3600 Chestnut Street Philadelphia, Pa. 19104 (215) 387-8000
RESIDENCE INN MARRIOT	600 W Swedesford Road Berwyn, PA 19132 (610) 640-9494

In-home Hospitality for families and patients (See next page)

ADDITIONAL HOUSING IN OUR LOCAL NEWSPAPERS:

CITY PAPER	(215) 735-8444
PHILADELPHIA WEEKLY	(215) 563-7400

Hosts for Hospitals
In-home Hospitality for Families and Patients

From their website:

"Our Purpose...

is to provide free lodging and support at volunteer-host homes as a caring response to the housing needs of patients and their families who come to the Greater Philadelphia area for specialized medical care.

Each year, thousands of people travel to the Philadelphia area seeking medical care. Almost every patient has someone travel along to provide support. Often these people, and even the patients themselves, arrive in desperate need of convenient, inexpensive lodging.

Hosts for Hospitals meets their needs through our network of volunteer host homes. Our hosts are caring people who provide a place to sleep and a feeling of home. Guests are able to return to the hospital each day refreshed and thus able to best offer support to their loved one."

How to Contact Hosts for Hospitals

Website:
www.hostsforhospitals.com

Phone:
215.472.3801

Fax:
215.472.3801

E-Mail:
Mike Aichenbaum, Executive Director
info@hostsforhospitals.org

Snail Mail:
4719 Pine Street » Philadelphia, PA 19143

DIRECTIONS TO:
The Center for the Treatment and Study of Anxiety
3535 Market Street, 6th Floor
Philadelphia, PA 19104

FROM NORTHERN SUBURBS:

- Take I-95 South to I-676 West (Central Philadelphia).
- Continue on I-676 West to the junction with I-76.
- Take the exit for I-76 East (toward Philadelphia Airport) and keep right.
- Exit immediately at Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street.
- The Center is at the corner of 36th and Market on the right.

FROM WEST:

- Take I-76 East toward Central Philadelphia.
- Take Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street.
- The Center is at the corner of 36th Street and Market Street on the right.

FROM SOUTHERN NEW JERSEY:

VIA BENJAMIN FRANKLIN BRIDGE:

- Take Ben Franklin Bridge into Philadelphia, continue on I-676 West to junction with I-76.
- Take the exit for I-76 East (toward Philadelphia Airport) and keep right.
- Exit immediately at Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street.
- The Center is at the corner of 36th Street and Market Street on the right.

VIA WALT WHITMAN BRIDGE:

- Take Walt Whitman Bridge into Philadelphia, continue on I-76 West to Exit 346A-South Street (old Exit 40). ***This exit is from the left lane***
- Turn left at the top of the ramp onto South Street.
- Continue past Franklin Field (football stadium) to the second traffic light.
- Turn right onto 33rd Street.
- Continue on 33rd Street to the third traffic light and turn left onto Market Street.
- The Center is at the corner of 36th and Market on the right.

FROM NORTHERN NEW JERSEY AND NEW YORK:

- Take I-295 South to Exit 27 (I-76, Walt Whitman Bridge, Philadelphia).
- Take Walt Whitman Bridge into Philadelphia, continue on I-76 West to Exit 346A-South Street (old Exit 40). ***This exit is from the left lane***
- Turn left at the top of the ramp onto South Street.
- Continue past Franklin Field (football stadium) to the second traffic light.
- Turn right onto 33rd Street.
- Continue on 33rd Street to the third traffic light and turn left onto Market Street.
- The Center is at the corner of 36th and Market on the right.

FROM PHILADELPHIA INT'L. AIRPORT, DELAWARE COUNTY, AND DELAWARE:

- Take I-95 to I-676 West (Central Philadelphia). ***This exit is from the left lane***
- Continue on I-676 West to the junction with I-76.
- Take exit for I-76 East (toward Philadelphia Airport) and keep right.
- Exit immediately at Exit 345 (old Exit 39) for 30th Street Station.
- At the top of the ramp, turn right, then follow traffic to the left around train station.
- Turn right at the second traffic light onto Market Street.
- Continue on Market Street to 36th Street.
- The Center is at the corner of 36th and Market on the right.

FROM 3Oth STREET STATION (via AMTRAK or SEPTA Regional Rail Lines):

- From 30th Street Station you can take a taxi or walk six blocks West on Market to 36th and Market Streets. The Center is located on the ride side of Market Street at the corner of 36th Street.
- Alternate: Take the westbound Route 10 subway-surface trolley from the 30th Street Subway Station. Get off at the first stop after the trolley surfaces onto the street, 36th at Market. The center is located on the right side of Market Street.

VIA SUBWAY/TROLLEY:

- Take the Market-Frankford subway line to 34th Street Station. Exit the tunnel and walk two blocks west to 36th Street. The Center is on the right side of Market Street at the corner of 36th Street.
- Alternate: Take Market-Frankford subway line to 30th Street station. Change for the westbound Route 10 trolley. Get off at the first stop after the trolley surfaces onto the street, 36th at Market. The Center is located on the right side of 36th Street on the far side of Market.

VIA BUS:

- The Center is located at the northeast corner of 36th and Market Streets.
  This area is served by the following bus routes:
- Route 21 at 36th Street and Walnut Street (westbound) or Chestnut Street (eastbound)
- Routes 30 and 31 at 34th Street and Market Street
- Route 40 at 36th Street and Spruce Street

PARKING: Paid parking is available on the street (parking kiosks) and in nearby lots